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M2100.000 FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

M2110.100 FAMIS GENERAL INFORMATION

A. Introduction

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program, enacted as Title XXI of the Social Security Act, to provide funds to States to enable them to initiate the provision of child health insurance to **uninsured low-income children**.

FAMIS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The Department of Medical Assistance Services (DMAS) will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Initial eligibility for FAMIS is determined by local DSS, including DSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Children found eligible for FAMIS receive benefits described in the State's Title XXI Child Health Insurance Program. Eligible children are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. There is no retroactive coverage in FAMIS. Case management and ongoing case maintenance, and selection for managed care are handled by the FAMIS CPU.

B. Legal Base

The 1998 Acts of Assembly, Chapter 464, authorized Virginia's Children's Health Insurance Program by creating the Children's Medical Security Insurance Plan for uninsured children under 19 years of age. In August 2001, the program was revised and renamed the Family Access to Medical Insurance Security Plan (FAMIS).

C. Policy Principles

FAMIS covers uninsured low-income children under age 19 who are not eligible for Medicaid and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the family size (see [M2130.100](#) for the definition of the FAMIS assistance unit and [Appendix 1](#) for the income limits).

A child is eligible for FAMIS if all of the following are met:

- he is **not** eligible for Medicaid due to excess income;
- he is under age 19 and a resident of Virginia;
- he is uninsured;
- he is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency or a local governmental agency that participates in the Local Choice Program and contributes to the cost of dependent health insurance (see [Appendix 2](#) and [Appendix 3](#) to this chapter);
- he is **not** a member of a family who has dropped health insurance coverage on him within 4 months of the application without good cause;
- he is **not** an inmate of a public institution;
- he is **not** an inpatient in an institution for mental diseases;
- he meets the Medicaid Nonfinancial Eligibility Requirements in Chapter [M02](#) with certain exceptions; and
- he has gross family income less than or equal to 200% FPL.

M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

The child must meet, with certain exceptions, the Medicaid Nonfinancial Eligibility Requirements in chapter [M02](#) and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Requirements

The Medicaid Nonfinancial Eligibility Requirements in Chapter [M02](#) that must be met are:

- citizenship and alienage requirements;
- Virginia residency requirements;
- institutional status requirements regarding inmates of a public institution.

C. M02 Exceptions

The exceptions to the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 are:

1. Alienage Requirements

FAMIS alienage requirements are different from the Medicaid alienage requirements. Citizens and qualified aliens who entered before August 22, 1996 meet the citizenship/alienage requirements and are not subject to time limitations.

*a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **without regard to time limitations**:*

- *refugees (see [M0220.310 A. 2](#)),*
- *asylees (see [M0220.310 A. 4](#)),*
- *veteran or active military (see [M0220.311](#)),*
- *deportation withheld (see [M0220.310 A. 6](#)), and*
- *victims of a severe form of trafficking (see [M0220.313 A.52](#))*

*b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **after 5 years of residence in the United States**:*

- *lawful permanent residents (LPR),*
- *conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),*
- *aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and*
- *battered aliens, alien parents of battered children, alien children of battered parents.*

Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements.

Appendix 7, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.

2. SSN

A Social Security Account Number (SSN) or proof of application for a SSN ([M0240](#)) is **not** a requirement for FAMIS.

3. Assignment of Rights

The child's parent or legal custodian must meet the requirements for the assignment of rights to payment for medical care from any liable third party.

4. HIPP

Application requirements for the Health Insurance Premium Payment (HIPP) program ([M0290](#)) do not apply to FAMIS.

**D. FAMIS
Nonfinancial
Requirements**

The child must meet the following FAMIS nonfinancial requirements:

**1. Age
Requirement**

The child must be under age 19. No verification is required.

The child no longer meets the age requirements for FAMIS as of the end of the month in which the child reaches age 19.

**2. Uninsured
Child**

The child must be uninsured, that is, he must not be covered under any health insurance plan offering hospital and medical benefits. See M2120.200.

**3. State Employee/
Local Choice
Prohibition**

A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency. A child is also ineligible for FAMIS if he is a member of a family eligible for health benefits coverage on the basis of a family member's employment with a local governmental agency that participates in the Local Choice Program and the employer contributes to the cost of dependent health insurance.

**4. IMD
Prohibition**

The child cannot be an inpatient in an institution for mental diseases (IMD).

M2120.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated. Acquisition of health coverage for a child during enrollment in FAMIS is cause for termination.

B. Definitions

**1. Creditable
Coverage**

For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:

- church plans and governmental plans;
- health insurance coverage, either group or individual insurance;
- military-sponsored health care;
- a state health benefits risk pool;
- the federal Employees Health Benefits Plan;
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term limited coverage.

- 2. Employer Sponsored Dependent Health Insurance** Employer sponsored dependent health insurance (ESHI) means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer sponsored insurance.
- 3. Family Member** When determining whether the child is eligible for coverage under a State Employee Health Insurance Plan, family member means parent(s), and a stepparent with whom the child is living if the stepparent claims the child as a dependent on his federal tax return.
- 4. Health Benefit Plan** “Health benefit plan” is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:
- “any accident and health insurance policy or certificate,
 - health services plan contract,
 - health maintenance organization subscriber contract,
 - plan provided by a Multiple Employer Welfare Arrangement (MEWA)”.
- Health benefit plan does not mean:
- accident only;
 - credit or disability insurance;
 - long-term care insurance;

- dental only or vision only insurance;
- specified disease insurance;
- hospital confinement indemnity coverage;
- limited benefit health coverage;
- coverage issued as a supplement to liability insurance;
- insurance arising out of workers' compensation or similar law;
- automobile medical payment insurance; or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

5. Insured

means having creditable health insurance coverage or coverage under a health benefit plan.

6. Uninsured

means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the child resides.

C. Policy

A nonfinancial requirement of FAMIS is that the child be uninsured. A child **cannot**:

- have creditable health insurance coverage;
- have coverage under a group health plan (*TRICARE*, federal employee benefit plan, private group insurance such as *Anthem*, etc.);
- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see [Appendix 3](#) to this chapter];
- be a member of a family eligible for health benefits coverage on the basis of a family member's employment with a public agency in the State that participates in the Local Choice Program and the employer contributes to the cost of dependent health insurance (see [Appendix 2](#) to this chapter), or
- without good cause, have had creditable health insurance coverage terminated within 4 months prior to the month of application.

Good cause reasons are listed in [E.](#) below.

**D. Health
Insurance
Coverage
Discontinued**

A child is ineligible for FAMIS coverage if his creditable health insurance coverage was terminated without good cause within 4 months prior to the month for which eligibility is being established.

Example: A child's health insurance was terminated without good cause in November. A FAMIS application was filed the following February. The child is ineligible for February because his health insurance was terminated within 4 months of November. He may be eligible in March because his insurance was terminated more than 4 months prior to March.

NOTE: For purposes related to FAMIS eligibility, a child is NOT considered to have been insured if health insurance coverage was provided under Medicaid, HIPP, FAMIS, or if the insurance plan covering the child does not have a network of providers in the area where the child resides.

**E. Good Cause for
Dropping Health
Insurance**

The ineligibility period can be waived if there is good cause for the discontinuation of the health insurance. A parent, guardian, legal custodian, authorized representative, or adult relative with whom the child lives may claim to have good cause for the discontinuation of the child(ren)'s health insurance coverage. The local agency will determine that good cause exists and waive the period of ineligibility if the health insurance was discontinued for one of the following reasons:

- The family member who carried insurance changed jobs or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The employer stopped contributing to the cost of family coverage and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The child's coverage was discontinued by an insurance company for reasons of uninsurability, e.g. the child has used up lifetime benefits or the child's coverage was discontinued for reasons unrelated to payment of premiums. Verification is required from the insurance company.
- Insurance was discontinued by a family member who was paying the full cost of the insurance premium under a COBRA policy AND no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- Insurance on the child is discontinued by someone other than the child (if 18 years of age), or, if under age 18, the child's parent or stepparent, e.g. the insurance was discontinued by the child's grandparent, aunt, uncle, godmother, etc. Verification is not required.
- Insurance on the child is discontinued because the cost of the *health insurance premiums for all family members* exceeds 10% of the family's GROSS monthly income or exceeded 10% of the family's GROSS monthly income at the time the insurance was discontinued.

Documentation of the amount of the monthly *health insurance* premiums *for all family members* is required. If the amount of the premium is less than or equal to 10% of the family's current gross monthly income, a declaration from the family will be requested as to the amount of gross monthly income received at the time the *child(ren)*'s insurance was discontinued.

1. Use the applicant's month-prior-to-application gross income verification.
2. Calculate 10% of the family's gross monthly income.
3. Compare to *total amount of* monthly premiums.
4. If monthly premium is less than or equal to 10% of current gross monthly income:
 - a. Ask applicant "what was your family's gross income in the month in which you discontinued the health insurance (include all amounts of income received in that month)?" Document the applicant's statement in the record.
 - b. Calculate 10% of the family's gross monthly income (in the month in which the insurance was discontinued).
 - c. Compare to *total amount of* monthly premiums.
 - 1) If monthly premiums *are* less than or equal to 10% of this gross monthly income, good cause is NOT met. The children are not eligible for 4 months following the discontinuance of the insurance.
 - 2) If monthly premiums *are* more than 10% of this gross monthly income, good cause is met and there is no waiting period for FAMIS.
5. If monthly premiums *are* more than 10% of current gross monthly income, good cause is met and there is no waiting period for FAMIS.

M2120.300 NO CHILD SUPPORT REQUIREMENTS

A. Policy There are no child support requirements for FAMIS.

M2130.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. **FAMIS
Assistance
Unit**

The FAMIS assistance unit consists of:

- the child applicant under age 19;
- the parent(s) and stepparent who live in the home with the child; and
- any siblings, half-siblings, and stepsiblings under age 19 who live in the home with the child.

NOTE: Medicaid family/budget unit rules do not apply to FAMIS.
A child who is pregnant is counted as 1 individual; DO NOT
COUNT the unborn child.

2. **Asset Transfer**

Asset transfer rules do not apply to FAMIS.

3. **Resources**

Resources are not evaluated for FAMIS.

4. **Income**

The FAMIS income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the FAMIS assistance unit.

The source and amount of all income other than Job Training Partnership Act (JPTA), Workforce Investment Act, and student income must be verified and counted. FAMIS uses the same income types and methods for estimating income as Medicaid (see chapter M07). There are no income disregards and no budget units in FAMIS.

5. **Spenddown**

Spenddown does not apply to FAMIS. If the family's gross income exceeds the FAMIS income limits, the child is not eligible for the FAMIS program regardless of medical expenses.

M2140.100 APPLICATION and CASE PROCEDURES

A. **Application
Requirements**

The Application for Children's Health Insurance in Virginia (see Appendix 4) is the application form for FAMIS. The Application for Benefits or the ADAPT Statement of Facts *are also acceptable application/renewal forms* for FAMIS.

The parent, legal guardian, authorized representative, or an adult relative with whom the child lives must sign the application. The adult relative must be related by blood or marriage. Documentation of the relationship is not required. The child's parent or legal guardian may designate in writing an authorized representative to complete and sign the application. The date of the application is the date the application is received at the local DSS, including DSS outstationed sites, or at the FAMIS CPU.

Applications can be mailed to the local DSS or the CPU. A face-to-face interview is not required.

**B. Eligibility
Determination**

When an application is received and the child is not eligible for Medicaid due to excess income, determine eligibility for FAMIS. In order to complete an eligibility determination, both the FAMIS nonfinancial requirements in [M2120.100](#) and the financial requirements in [M2130.100](#) must be met. The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received. Applications must be acted on as soon as possible, but no later than 45 days from the date the signed application was received at the local DSS or the FAMIS CPU. Cases approved for FAMIS must be transferred to the FAMIS CPU for case management and ongoing case maintenance.

**C. Entitlement and
Enrollment**

Children determined eligible for FAMIS are enrolled for benefits in the Medicaid Management Information System (MMIS) effective the first day of the child's application month if all eligibility requirements are met in that month, **but no earlier than the date of the child's birth. There is no retroactive coverage in the FAMIS program.**

The PDs for FAMIS are:

PD	Meaning
06	child under age 6 with income > 150% FPL and ≤ 200% FPL
07	child 6 - 19 with income > 150% FPL and ≤ 200% FPL
08	child under age 6 with income > 133% FPL and ≤ 150% FPL
09	child 6 - 19 with income > 133% FPL and ≤ 150% FPL

Because Medicaid and FAMIS are separate programs, Medicaid eligible individuals and FAMIS eligible children cannot share the same case number in the MMIS. When a child is determined eligible for FAMIS and the child has family members enrolled in Medicaid in the MMIS, the FAMIS child must be given a new case number when enrolled in the MMIS. Only children eligible for the same program can share the same base case number in the MMIS.

After the child is enrolled in the MMIS, the local DSS worker must change the MMIS worker number to V000 to transfer the case to the FAMIS CPU. The local DSS worker must not change the FIPS code or make any other change to the case after the case has been transferred to FAMIS in the MMIS.

**D. Notification
Requirements**

1. Notice of Action

The local DSS worker must send a Notice of Action on Medicaid and FAMIS to the family informing them of the action taken the application. The notice must include the eligibility determination for both Medicaid and FAMIS.

If the child is eligible for FAMIS, the notice must inform the family that the case has been transferred to FAMIS and that further information on the program will come from FAMIS.

If the child is ineligible for both Medicaid and FAMIS, the family must be sent a notice that the child is not eligible for either program and must be given the opportunity to have a Medicaid medically needy evaluation. Along with the notice, send the Application for Benefits to the family and advise them that if the signed application is returned within 10 days, the original application date will be honored.

**2. Transfer to
FAMIS CPU**

Once the enrolled case is transferred in the MMIS and the notice is sent to the family, the eligibility worker must send to the FAMIS CPU:

- the original application, any supplements and verifications used to determine FAMIS eligibility, and
- the case record transfer form.

Cases must be sent to the FAMIS CPU, FIPS 976, via the courier the day of enrollment or the next working day.

The FAMIS CPU will send the local DSS the signed copy of the case transfer form confirming receipt of the case.

**3. Communica-
tion Between
Local DSS and
the FAMIS
CPU**

The Children's Health Insurance Communication form (see [Appendix 6](#) to this chapter) is used to request cancellation of FAMIS coverage of children found eligible for Medicaid, report changes and communicate information between local DSS and the FAMIS CPU.

**E. Employer
Sponsored Health
Insurance (ESHI)**

Under the FAMIS program, families that have access to health insurance through their employer have the option of enrolling the family in the employer's health plan if the coverage under the employer's plan does not

cost the State any more than it would cost to cover the children in FAMIS. Children enrolled in FAMIS whose families have access to ESHI coverage may qualify to have the State pay part of the family's share of the health insurance premium as long as all of the following conditions are met:

- the employer must pay at least 40% of the cost of the family health insurance
- the cost of covering the child under the employer-sponsored health insurance (ESHI) plan has to be less than or equal to the cost of covering the child under FAMIS
- the family must apply for the full premium contribution from the employer.

Once a child is enrolled in FAMIS, the FAMIS CPU will identify if the child has access to employer sponsored health insurance (ESHI). Families who have access to ESHI will receive information from the DMAS about the benefits of enrolling in the ESHI component of FAMIS and information about how to participate in the program. Participation in the FAMIS ESHI component is voluntary.

***F. 12-Month
Continuous
Coverage***

Children under age 19 who are enrolled in FAMIS are entitled to 12 months of continuous coverage provided the family continues to reside in Virginia and the family income is less than or equal to 200% of the FPL.

Children enrolled in FAMIS who subsequently apply for Medicaid and are found eligible must have their FAMIS coverage cancelled so they can be reinstated in Medicaid.

M2150.100 REVIEW OF ADVERSE ACTIONS

A. Case Reviews

An applicant for FAMIS may request a review of an adverse determination regarding eligibility for FAMIS. FAMIS reviews follow the procedures established by Medicaid for client appeals (see chapter [M16](#)).

The payment of medical services on the part of any child or any right to participate in the program is not subject to review if funds for FAMIS are exhausted.

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS) INCOME LIMITS ALL LOCALITIES EFFECTIVE 2/??/05				
# of Persons in FAMIS Assistance Unit	FAMIS 150% FPL		FAMIS 200% FPL	
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit
1	\$13,965	\$1,164	\$18,620	\$1,552
2	18,735	1,562	24,980	2,082
3	23,505	1,959	31,340	2,612
4	28,275	2,357	37,700	3,142
5	33,045	2,754	44,060	3,672
6	37,815	3,152	50,420	4,202
7	42,585	3,549	56,780	4,732
8	47,355	3,947	63,140	5,262
each add'l person add	4,770	398	6,360	530

LOCAL CHOICE AGENCIES – effective 07/01/04

(Agencies added 7-1-04 are in bold)

Altavista, Town of
Amelia County Board of Supervisors
Amelia County School Board
Amherst County Board of Supervisors
Amherst County Service Authority*
Bath, County of
Bedford County Public Service Authority
Blackstone, Town of
Blue Ridge Regional Jail Authority Until 07/01/05
Bluefield, Town of
Brookneal, Town of
Brunswick County Public Schools
Buckingham, County of
Charlottesville-Albemarle Airport Authority
Carroll County Public Schools
Cedar Bluff, Town of
Center of Innovative Technology
Central Shenandoah Planning District Commission
Central Virginia Regional Jail
Charlottesville-Albemarle Airport Authority
Chesapeake Bay Bridge & Tunnel District
Clintwood, Town of
Coeburn, Town of
Coeburn-Norton-Wise Regional Waste Water
Colonial Heights, City of
Covington City School Board
Craig County School Board
Crater Youth Care Commission
Cumberland Mountain Community Services Board
Danville Redevelopment and Housing Authority
Dayton, Town of
Dickenson County Department of Social Services
Dinwiddie County Public Schools
Dinwiddie, County of
District 19 Community Services Board
District Three Governmental Cooperative
Dublin, Town of
Eastern Shore Community Service Board
Edinburg, Town of
Emporia, City of
Fairfax, City of
Farmville, Town of
Franklin, City of
Franklin City Public Schools
Franklin Redevelopment and Housing Authority
Fredericksburg City Public Schools
Front Royal, Town of
Glade Spring, Town of

Gate City, Town of
Gordonsville, Town of
Goochland Schools and County
Greensville, County of
Greensville County School Board
Grundy, Town of
Halifax, Town of
Hampton Roads Regional Jail Authority
Haysi, Town of
Highlands Juvenile Detention Center Commission
J.R. Horsley Soil and Water Conservation District
John Flannagan Water Authority
King George, County of
King William, County of
Lebanon, Town of
Lee County Department of Social Services
Lee County Government
Lenowisco Planning District Commission
Lonesome Pine Regional Library
Lunenburg County Public Schools
Luray, Town of
Mathews County
Middle Peninsula Regional Security Center
Monacan Soil & Water Conservation District
Mount Jackson, Town of
Mount Rogers Planning District Commission
Narrows, Town of
Nelson, County of
New Kent, County (Only for County
Administrators, Dept. Heads, and Constitutional
Officers)
New Market, Town of (only if employee hired
before 12/16/96)
New River Valley Agency on Aging
New River Valley Planning District Commission
New River Valley Regional Jail
Northern Shenandoah Valley Regional
Commission
Northern Neck Regional Jail
Norton City Public Schools
Norton, City of
Page County Government
Pearisburg, Town of
Pembroke, Town of
Pennington Gap, Town of
Peter Francisco Soil and Water Conservation
District

Petersburg, City of
Powhatan County Public Schools
Powhatan, County of
Prince Edward County Public Schools
Prince William Soil & Water Conservation District
Purcellville, Town of
Radford City Schools
Rappahannock, County of
Rappahannock Juvenile Center
Regional Governor's School Global Economical and Technology
Rich Creek, Town of
Richlands, Town of
Richmond County Employees
Roanoke Valley-Alleghany Regional Commission
Roanoke Higher Education Authority
Round Hill, Town of
Scottsville, Town of
Saint Paul, Town of
Shenandoah County
South Central Wastewater Authority
Southampton County
Southampton County School Board
Southside Community Services Board
Southwest Virginia Regional Jail Authority
Spotsylvania County School Board
Strasburg, Town of
Sussex County School Board
Tazewell County
Tazewell County Department of Social Services
Tazewell County Public Schools (effective 10-01-04)
Tidewater Soil and Water Conservation District
Timberville, Town of
Urbanna, Town of
Virginia Biotechnology Research Park Authority
Virginia Dare Soil & Water Conservation District
Virginia Peninsulas Public Service Authority
Virginia Port Authority
Virginia Recreational Facilities Authority
Washington County School Board
Westmoreland County
Williamsburg-James City County Public Schools
Windsor, Town of
Wise County Board of Supervisors
Wise County School Board
Wise, Town of
Woodstock, Town of

STATE AGENCY LISTING - 07/30/02

Accountancy, Board of	Credit Union, Inc., Virginia
Accounts, Dept. of	Crime Commission, Virginia Stat
Administration, Secretary of	Criminal Justice Services, Dept. of
Aging, Dept. for the	Dabney S. Lancaster Community College
Agriculture and Consumer Services, Dept. of	Danville Community College
Alcoholic Beverage Control, Dept. of	Deaf and Hard of Hearing, Dept. for the
Arts, Virginia Commission for the	Delmarva Advisory Council
Atlantic States Marine Fisheries Commission	Eastern Shore Community College
Attorney General, Office of the	Eastern State Hospital
Auditor of Public Accounts	Economic Development Partnership, Virginia
Aviation, Dept. of	Education, Dept. of
Bar Examiners, State Board of	Education, Secretary of
Blind and Vision Impaired, Dept. for the	Elections, State Board of
Blue Ridge Community College	Emergency Management, Dept. of
Blue Ridge Hospital	Employment Commission, Virginia
Business Assistance, Virginia Dept. of	Employment Dispute Resolution, Dept. of
Capitol Police, Division of	Environmental Quality, Dept. of
Catawba Hospital	Finance, Secretary of
Center for Innovative Technology	Fire Programs, Dept. of
Central State Hospital	Forestry, Dept. of
Central Virginia Community College	Frontier Culture Museum of Virginia
Central Virginia Training Center	Game and Inland Fisheries, Dept. of
Charitable Gaming Commission	General Services, Dept. of
Chesapeake Bay Commission	George Mason University
Chesapeake Bay Local Assistance	Germanna Community College
Child Day Care & Early Childhood Programs,	Governor, Office of the
Virginia Council on	Gunston Hall
Christopher Newport University	Health and Human Resources, Secretary of
Civil Air Patrol	Health Professions, Dept. of
College of William and Mary	Health, Dept. of
Commerce and Trade, Secretary of	Higher Education for Virginia, State Council of
Commonwealth Center for Children and	Hiram W. Davis Medical Center
Adolescents	Historic Resources, Dept. of
Commonwealth Competition Council	House of Delegates
Commonwealth, Secretary of the	Housing and Community Development, Dept. of
Commonwealths Attorneys Services Council	Housing Development Authority, Virginia
Community College System, Virginia	Housing Study Commission, Virginia
Compensation Board	Human Resource Management, Dept. of
Conservation and Recreation, Dept. of	Human Rights, Council on
Corporation Commission, State	Information Technology, Dept. of
Correctional Education, Dept. of	J. Sargeant Reynolds Community College
Corrections, Dept. of	James Madison University
Court of Appeals of Virginia	Jamestown-Yorktown Foundation

John Tyler Community College Joint Commission on Health Care Joint Legislative Audit and Review Commission Judicial Inquiry and Review Commission Juvenile Justice, Dept. of Labor and Industry, Dept. of Legislative Automated Systems, Division of Legislative Services, Division of Liaison Office, Virginia Library of Virginia, The Lieutenant Governor, Office of the Local Government, Commission on Longwood University Lord Fairfax Community College Lottery, Dept. of the Marine Resources Commission Marine Science, Virginia Institute of Mary Washington College Medical Assistance Services, Dept. of Medical College of Virginia Melchers Monroe Memorials Mental Health, Mental Retardation & Substance Abuse Services, Dept Military Affairs, Dept. of Milk Commission Mines, Minerals and Energy, Dept. of Minority Business Enterprise, Dept. of Motor Vehicle Dealer Board Motor Vehicles, Dept. of Mountain Empire Community College Museum of Fine Arts, Virginia Museum of Natural History, Virginia Natural Resources, Secretary of New River Community College Norfolk State University Northern Virginia Community College Northern Virginia Mental Health Institute Northern Virginia Training Center Office of Commonwealth Preparedness Old Dominion University Outdoors Foundation, Virginia Parole Board, Virginia Patrick Henry Community College Paul D. Camp Community College People With Disabilities, Virginia Board for Piedmont Geriatric Hospital Piedmont Virginia Community College Planning and Budget, Dept. of	Port Authority, Virginia Potomac River Fisheries Commission Professional & Occupational Regulation, Dept. of Public Broadcasting, Virginia Public Defender Commission Public Safety, Secretary of Racing Commission, Virginia Radford University Rail and Public Transportation, Dept. of Rappahannock Community College Rehabilitation Center for the Blind & Visually Impaired Rehabilitative Services, Dept. of Retirement System, Virginia Richard Bland College (of William and Mary) Science Museum of Virginia Senate, Virginia State Social Services, Dept. of Southeastern Virginia Training Center Southern Virginia Mental Health Institute Southside Virginia Community College Southside Virginia Training Center Southwest Virginia Community College Southwestern Virginia Mental Health Institute Southwestern Virginia Training Center State Internal Auditor, Dept. of the State Police, Dept. of Supreme Court of Virginia Taxation, Dept. of Technology Planning, Dept. of Technology, Secretary of Thomas Nelson Community College Tidewater Community College Tourism Corporation, Virginia Transportation, Dept. of Transportation, Secretary of Treasury, Dept. of the University of Virginia University of Virginia College at Wise University of Virginia Medical Center VA School for the Deaf and Blind-Staunton VA School for Deaf, Blind & Multi-Disabled - Hampton Veterans Affairs, Dept. of Virginia Alcohol Safety Action Program, Commission on Virginia Baseball Stadium Authority Virginia College Savings Plan
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Virginia Commonwealth University
Virginia Criminal Sentencing Commission
Virginia Freedom of Information Advisory Council
Virginia Highlands Community College
Virginia Information Providers Network
Virginia Military Institute
Virginia Office for Protection and Advocacy
Virginia Polytechnic Institute and State University
Virginia Resources Authority
Virginia State Bar
Virginia State University
Virginia Treatment Center for Children
Virginia Veterans Care Center
Virginia Western Community College
Virginia Workers Compensation Commission
Western State Hospital
Western Tidewater Community Services Board
Woodrow Wilson Rehabilitation Center
Wytheville Community College
Youth, Commission on



Children's Health Insurance

This is an application for FAMIS and FAMIS Plus, Virginia's health insurance programs for children under age 19. Instructions are attached.

Application is: _____ a new application
_____ to continue insurance
Family ID # _____

Office Use Only: Case _____
Worker _____

Step 1 Information on the person completing the application:

Tell us who you are, where you live and where you get your mail.

First Name	MI	Last Name	Phone Numbers	Preferred Language? (See instructions)
			H () W ()	
Address		Apt No.	City	State
(Street)				
(Mailing)				
			ZIP	City/County of Residence

Step 2 Information on Children:

Tell us about **all** the children under age 21 living in your home. If there are more than four children in the home, please complete steps 2 and 3 on another application (or on an Additional Child Form) and attach it to this application.

	Child 1	Child 2	Child 3	Child 4
Child's Full Name (Name: First, MI, Last)				
Relationship to You				
Date of Birth & Sex	____/____/____ <input type="checkbox"/> M <input type="checkbox"/> F	____/____/____ <input type="checkbox"/> M <input type="checkbox"/> F	____/____/____ <input type="checkbox"/> M <input type="checkbox"/> F	____/____/____ <input type="checkbox"/> M <input type="checkbox"/> F
Child's Parent or Stepparent Living In the Home (Name: First, MI, Last)	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required
Child's Parent or Stepparent Living In the Home (Name: First, MI, Last)	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required

Step 3

Information on Children Applying for Insurance:

	Child 1 <i>continued</i>	Child 2 <i>continued</i>	Child 3 <i>continued</i>	Child 4 <i>continued</i>
Child's Full Name (Name: First, MI, Last)				
Applying for Health Insurance for Child?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If you are applying for insurance for this child, answer the questions below. If you are <u>not</u> applying for this child, you may leave them blank.				
Is Child a US Citizen?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If No , Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	If No , Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	If No , Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	If No , Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	If No , Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____
Child Social Security # or Date of Application for SS# (SS#) _____	(SS#) _____	(SS#) _____	(SS#) _____	(SS#) _____
Child Attends School?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Child's Race (See codes listed below)	Race Code # _____	Race Code # _____	Race Code # _____	Race Code # _____
Child's Ethnicity	RACE CODES: 1 White; 2 Black/African American; 3 American Indian/Alaskan Native; 4 Asian; 5 Spanish American/Hispanic; 6 Native Hawaiian or Other Pacific Islander; 9 Other or Unknown. Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO
Does Child Have Health Insurance Now? (See instructions for further explanation)	If YES , Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES , Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES , Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES , Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ <input type="checkbox"/> YES <input type="checkbox"/> NO
Has Child Had Health Insurance in the Past 4 Months? (See instructions for further explanation)	<input type="checkbox"/> YES <input type="checkbox"/> NO If YES , Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO If YES , Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO If YES , Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO If YES , Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____
Why Did Insurance End in the Past 4 Months? (See reasons below)	Reason # _____ Other _____	Reason # _____ Other _____	Reason # _____ Other _____	Reason # _____ Other _____

REASONS CHILD'S HEALTH INSURANCE ENDED: (See instructions)

1 Parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage. **2** Parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage. **3** Insurance company discontinued coverage because child is uninsurable. **4** Cost of insurance exceeded 10% of monthly income (before taxes). **5** Insurance stopped/dropped by someone other than parent or stepparent living with child. **6** Stopped/dropped a COBRA policy. **7** Other

Step 4

Income Information:

Complete the section below for each parent, stepparent and child living in the home receiving income. List each source of income separately. Include income from jobs, self-employment, child support, Social Security benefits, unemployment compensation, and any other income received. List all income amounts before taxes and other deductions (gross income). Do not include income received by guardians, grandparents or other relatives. If there is no family income, write "NONE" in the chart below. (See instructions for explanation of all types of income that must be listed and the proof of income that must be provided.)

Person Receiving Income	Employer's Name or Source of Income?	Is Employer a State or Local Government?	How Much Income is Received?	How Often is Income Received?
First Name MI Last Name		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
First Name MI Last Name		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
First Name MI Last Name		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
First Name MI Last Name		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
First Name MI Last Name		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly

We have your permission to get information from the above employers, if necessary, about dates of employment and earnings. ☐ YES ☐ NO

Step 5

Childcare Expenses:

Do you pay someone to provide childcare while you work? ☐ YES ☐ NO If yes, provide information for each child in childcare.

(Child's name: First, MI, Last)	How much do you pay? \$ _____	(Child's name: First, MI, Last)	How much do you pay? \$ _____	(Child's name: First, MI, Last)	How much do you pay? \$ _____	(Child's name: First, MI, Last)	How much do you pay? \$ _____
How often?		How often?		How often?		How often?	

You're almost done. Turn the page over, complete the application and remember to sign it.

Step 6 Help with Medical Bills:

If the child is eligible, FAMIS Plus may be able to help you with medical/dental services the child received in the last 3 months. Did any child you are applying for receive medical/dental services in the last 3 months? ☐ YES ☐ NO

If yes, list names of children and months in which they received medical/dental services:

Provide proof of income for the months that child received medical/dental care. **DO NOT SEND MEDICAL/DENTAL BILLS TO FAMIS.**

Step 7 Release:

If you would like to have someone else contact us for you, please complete the following:

I authorize (name) _____

and/or (organization) _____

(address) _____

(city) _____ (state) _____ (zip) _____ (phone) _____

to request and receive eligibility/enrollment information relating to my child(ren). I also permit FAMIS, the local Department of Social Services, and/or the Department of Medical Assistance Services to release information about this application to this person/organization.

By signing below I certify that I have read my **Rights and Responsibilities** (located on the instructions page) and agree to all the conditions and terms. I also agree that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report required changes promptly or on purpose, my children's health insurance may be denied or ended and I could be prosecuted for perjury, larceny and/or fraud.

SIGNATURE (REQUIRED) _____

DATE _____



Children's Health Insurance

Application Instructions & Rights and Responsibilities

APPLICATION INSTRUCTIONS FOR FAMIS & FAMIS Plus

(FAMIS Plus is the new name for children's Medicaid)

How do I apply?

To get started, simply call our toll-free number **1-866-87-FAMIS (1-866-873-2647)** or fill out this application and mail it to **FAMIS P.O. Box 1820, Richmond, Virginia 23218-1820**, or fax it to **toll-free fax number 1-888-221-9402**. This application can also be mailed, dropped off or faxed to the **local Department of Social Services** in the City or County in which you live. Check the blue pages in your telephone book for the address and telephone number of your local Department of Social Services. It is not required that you visit FAMIS or your local Department of Social Services to apply.

Who can apply for a child?

Parents can apply for their children. An adult relative with whom the child lives may also sign an application on behalf of the child. An adult who has legal custody or guardianship may apply for a child but will need to attach a copy of court papers. A person authorized in writing, by a parent or legal guardian, to act on behalf of the parent may apply but must attach a signed authorization from the parent. Adults, married to a minor, may apply for their spouse, and children over 18 or emancipated by a court, may apply for themselves.

Step 1 Information on person completing application: Complete this section listing your name, address and phone number. If we may call you at work, include that phone number. Please tell us what language you prefer. Write the name of the language you prefer in the space provided, such as:

English, Spanish, Cambodian, Vietnamese, Farsi, Haitian-Creole, Laotian, Chinese, Korean, Somali, Kurdish, Arabic, French, German, Japanese, or any other language.

Step 2 Information on children: Provide information on all children under 21 who live in the home with you even if they are not applying for FAMIS or FAMIS Plus. Although you can only apply for children under age 19 on this form, we need information on all children under 21 to correctly determine the size of the family. If there are more than 4 children under age 21 in the home, complete sections 2 and 3 on another application and attach it to this one.

List the **name** of each child under age 21 who lives in the home with you, tell us how they are **related to you**, their **date of birth**, and check if they are **male or female**.

For each child under age 21 in the home please write the **name** of the child's **parents and/or stepparents** living in the home with the child. Check if they are the Mother, Father or Stepparent of the child. The Social Security Number (SS#) of each parent is not required information but it helps us check income and process the application. If you prefer, you may leave it blank.

Step 3 Information on children applying: Write the **name** of each child at the top of the same column again. Check whether you are **applying for health insurance** for each child. If you are not applying for health insurance for a child, you do not need to answer the rest of the questions in this section for that child. If you are applying for the child, answer all of the questions in the column.

If the child is a **US citizen** check yes. If the child is a **legal immigrant**, provide the child's **INS #**, country of birth and the date the child entered the U.S. Children who are legal residents may qualify for these health insurance programs. You must provide a copy of the front and back of the child's Resident Alien Card or other proof of immigration status with this application. This information is for our records only and will not affect the immigration status of your children and will not be shared with the INS. We do not need information on the immigration status of any adults in your family. The INS cannot use this application to deny you admission to the U.S., to harm your permanent resident status, or to deport you.

Unless you are applying solely for emergency medical services for a non-citizen child, a **Social Security Number** is required for all children

applying for health insurance. If the child does not have a Social Security Number, you must provide proof that you have applied for one for the child.

Tell us if the child is currently **attending school**.

Enter the correct code number for the **Race** of each child. Codes are listed below the question on the application. Then check yes or no if the child is of Hispanic/Latino ethnic origin.

Having other health insurance does not affect a child's eligibility for FAMIS Plus but may affect eligibility for FAMIS. Tell us if your children have health **insurance now**, and what type of policy they have. (For example, comprehensive coverage, major medical, school-accident plan, dental coverage, etc.) Provide the name of the insurance company and the policy number.

Children are not eligible for FAMIS until they have been uninsured for 4 months unless there was a "good cause" **reason why the health insurance ended**. Tell us if each child had health insurance during the past **4 months**. If they did, tell us about the policy and the date it ended. Read the good cause reasons listed on the application and if any of them are true for this case, write the correct reason number in the space. If none of these reasons are correct, put #7 for "Other" and write a brief explanation of why the insurance ended. If the child's insurance was stopped because of the cost, (reason #4) you must provide proof of the monthly cost of the discontinued insurance. If the child's coverage was discontinued by an insurance company for a reason other than non-payment of premiums (reason #3), provide proof of this from the insurance company. If you want a further explanation of the good cause reasons or more information on what to include with the application, call **1-866-87-FAMIS** or your **local Department of Social Services**. **This rule does not apply to FAMIS Plus.**

Step 4 Income information: For each parent, stepparent and child under age 21 who lives in the home and receives income, list their **name** and the **source of the income**. If the income is from a job, list the name of the employer. If the income is from another source, (such as child support, unemployment compensation, Social Security, etc.) write the type or source of the income. Check if the person works for the **State of Virginia** or for a **local government agency**.

For each type of income listed, write the **amount of income** received and how often it is received (**each week, every two weeks, twice a month, once a month or yearly**). Be sure to write the amount of income before any taxes or other deductions are taken out (gross income).

You also need to provide **proof of each type of income** a family member receives. You will need to provide proof of all income received in the month before you apply. (For example, if you were

applying in June, you would need to attach proof of all income received in the month of May. If you were applying in May you would need to provide proof of all income for April.)

To prove income from a job, please attach a copy of all paycheck stubs for last month showing gross pay. If you do not have paycheck stubs, you can send a signed letter from an employer stating how much the employee was paid for each pay period last month or you may call 1-866-87-FAMIS to request a special form for reporting employment income. If you are self-employed, provide your most current tax return and all schedules or business records for last month.

You must also provide proof of other types of income received. Examples of proof of other income include: Child support — a print out from the Division of Child Support Enforcement Web site for last month, or copies of all child support checks received last month, or a signed statement from the absent parent stating how much they pay each month; Social Security (SSA or SSI) — the current year award letter from the Social Security Administration; unemployment compensation — a copy of all checks received last month.

If income is different from month to month, you may provide proof of the last 3 months of income to show an average income. If you have questions about what income to report or what proof is needed, please call 1-866-87-FAMIS or your local Department of Social Services.

Permission to contact employers: In some situations we may need to contact employers to get information about earnings. If you agree to let us do this in order to process this application, check yes.

Step 5 Childcare Expenses: Certain childcare expenses may help a child qualify for FAMIS Plus. Tell us if you **pay for childcare while** you work. If the answer is yes, write the **name** of each child in paid childcare and how much you pay for their childcare and how often you pay it. (For example, \$50 a week or \$200 a month.) You can even report this expense if you are paying a relative to care for the children. Also, report payments you make for adult daycare for an adult in your home that needs special care while you work.

Step 6 Medical Bills: If a child qualifies for FAMIS Plus, you may be able to get help with the child's **medical and dental bills for the past 3 months**. Tell us if a child applying for insurance has any medical bills during the last 3 months. If the answer is yes, write the **name** of the child or children who have medical bills and the **month** in which the child or children received the medical or dental service. You will also have to show proof of family income for that month so we can determine if the child or children would have qualified for FAMIS Plus at the time the medical care was received. If a child qualifies for FAMIS instead of FAMIS Plus, medical bills will only be covered from the first day of the month in which your signed application was received by FAMIS or at the local Department of Social Services. **DO NOT SEND MEDICAL OR DENTAL BILLS TO FAMIS OR FAMIS Plus.** If the child qualifies for this retroactive coverage, we can pay for bills submitted by doctors, hospitals, dentists, pharmacies, or other medical providers for medical/dental services provided to the child during that time. We cannot pay for bills sent from individuals.

Step 7 RELEASE: If someone has helped you with this application or you would like someone else to be able to receive information about this application on your behalf, **clearly print the person's name** or the name of an **organization** in this section. We will not release any information about this application to anyone except you, unless you tell us here who you want to be able to receive this information.

Before you sign this application, make sure all the information is correct and read the section on your **Rights and Responsibilities** carefully. When you sign the application you are agreeing to all the statements under the Rights and Responsibilities. **Sign and date the application.** We cannot process an unsigned application.

Final checklist: ☐ Did you answer all the questions?
☐ Did you attach proof of all of last month's income?
☐ Did you attach any other necessary documents?
☐ Did you sign the application?

Mail or fax to FAMIS or your local Department of Social Services today.

YOUR RIGHTS AND RESPONSIBILITIES

(Read this section before signing the application)

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs, or disability consistent with state and federal law and I can file a complaint if I feel I have been discriminated against.
- Request, in writing, a hearing or review of any negative action that affects my child(ren)'s eligibility for or receipt of FAMIS or FAMIS Plus (formerly Medicaid) insurance, including timely decisions made on this application. I understand that there will be no opportunity for review of a negative action if the sole basis for the action is lack of funding for FAMIS.
- Receive services from the Division of Child Support Enforcement and receive the booklet "Child Support and You". I further understand that failure to apply for such services will not affect my child(ren)'s eligibility for FAMIS or FAMIS Plus.

I further understand and agree that:

- This application could lead to my child(ren)'s enrollment in either FAMIS **OR** FAMIS Plus and that my child will be enrolled in the appropriate program based on eligibility rules.
- My children are not eligible for FAMIS coverage if they are eligible for FAMIS Plus, if they are eligible for health coverage under the Commonwealth of Virginia's State Employee Health Insurance Plan, or if they are patients in an institution for mental diseases. Children who are inmates in a public correctional institution are ineligible for both FAMIS and FAMIS Plus.
- The State and its contractors may contact other state and federal agencies to verify any information that affects my child(ren)'s eligibility for insurance.
- The State and its contractors may exchange information on this application

and medical, health, or other information relating to my child(ren)'s coverage with other agencies and contractors, including companies offering health insurance to my child(ren), to assist with application, enrollment, administration, quality control, and quality assurance. We will not share your information with the IRS or the INS.

- The Commonwealth of Virginia or its designee has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by my child(ren).
- Each provider of medical services to my child(ren) may release any medical or other information necessary for the provider to be paid.

If my child is enrolled in FAMIS, I understand:

- I will be responsible for paying a co-payment for some FAMIS services received by my child(ren) and the FAMIS case will be maintained by the FAMIS Central Processing Unit (CPU).
- I have the responsibility to report within 10 days of the change, certain increases in income or changes in family size as explained in the FAMIS handbook and if the child enrolled in FAMIS moves out of the state of Virginia. I must report such changes to the FAMIS CPU at 1-866-873-2647.

If my child is enrolled in FAMIS Plus, I understand:

- That FAMIS Plus was formerly known as Medicaid. The FAMIS Plus case will be maintained by the local Department of Social Services where the child lives.
- I have the responsibility to report any changes in information provided on this form within 10 days of the change. I must report this information to the local Department of Social Services that maintains the child's FAMIS Plus case.

FAMIS AND FAMIS PLUS MUST BE RENEWED AT LEAST **EVERY 12 MONTHS**.

IT IS VERY IMPORTANT THAT YOU REPORT ANY CHANGE IN YOUR ADDRESS TO THE AGENCY THAT IS MANAGING THE CHILD'S CASE. IF WE DO NOT HAVE A CORRECT ADDRESS, WE WILL NOT BE ABLE TO NOTIFY YOU WHEN IT IS TIME TO RENEW COVERAGE AND THE CHILD WILL BE CANCELLED FROM THE PROGRAM.

HELP US KEEP YOUR CHILDREN COVERED — TELL US IF YOU MOVE!

COMMONWEALTH OF VIRGINIA DEPARTMENT OF SOCIAL SERVICES FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS) SUPPLEMENTAL APPLICATION FORM For use with: Application/Redetermination for Medicaid Medically Indigent Children and Pregnant Women (#032-03-040) Application for Benefits (#032-03-824) ADAPT Statement of Facts	AGENCY USE ONLY	
	DATE RECEIVED _____	
	CASE NAME/NUMBER _____	
	LOCALITY _____	WORKER _____

Please complete all sections of the application. If you need assistance, please contact an eligibility worker at your local DSS.

1. Parent, Guardian, Authorized Representative or Caretaker Relative Information: Tell us who you are, where you live and where you get your mail.

First Name	MI	Last Name	Phone Numbers	What language do you prefer?
			H () _____ W () _____	English _____ Spanish _____ Other _____

	Address	Apt No.	City	State	Zip	City/County of Residence
Street						
Mailing						

2. List the names of the children applying for FAMIS.

a.	d.
b.	e.
c.	f.

3. Health Insurance Information:

Did any of the children listed above have health insurance in the past 6 months? _____ No _____ Yes If yes, (a) list name of child, type of insurance he or she had, such as doctor, hospital, drugs, dental, vision, etc., and the date the insurance ended; and (b) check the appropriate box to show why the insurance ended.

Name of child _____ Type of insurance _____

Date ended _____

Reason insurance ended:

The parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage.

The parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage.

Child uninsurable—insurance company discontinued coverage. (Provide proof that coverage stopped by insurance company)

Cost exceeded 10% of monthly income (before taxes). (Provide proof of cost of monthly premium)

Stopped/dropped by someone other than parent or stepparent.

Other _____

4. Is any member of the family, including a stepparent who lives in the home, employed by a State or Local Government agency?

_____ No _____ Yes If yes, please list name of family member(s) and agency name: _____

5. Medicaid or FAMIS can sometimes help with the cost of health insurance from your employer. Help us decide if this is possible.

Does the employer of any member of the family offer health insurance for family members? _____ No _____ Yes If yes,
name of employer _____. Can you get health insurance for the children listed on the application through
this employer? _____ No _____ Yes

6. Release: If you would like to have someone else contact us for you, please complete the following.

I authorize (name) _____ (and/or organization) _____
(address) _____ (city) _____ (state) _____ (zip) _____
(phone) _____ to request and receive eligibility and enrollment information relating to my child(ren). I also permit FAMIS,
the local Department of Social Services, and/or the Department of Medical Assistance Services to release information about this application to this
person/organization.

Your Rights and Responsibilities

By signing below, I agree to the following:

- a) I have the right to:
- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs or disability consistent with state and federal law and to file a complaint if I feel I have been discriminated against.
 - Request, in writing, a hearing or review of any negative action that affects my child(ren)'s eligibility for or receipt of FAMIS benefits, including timely decisions made on this application. I understand that there will be no opportunity for review of a negative action if the sole basis for the action is termination or exhaustion of funding for FAMIS.
 - Apply for and receive services from the Division of Child Support Enforcement and receive the booklet "Child Support and You". I further understand that failure to apply for such services will not affect my child(ren)'s eligibility for Medicaid or FAMIS.
- b) I further understand and agree that:
- My child(ren) is ineligible for FAMIS coverage if he (1) is eligible for Medicaid or for health coverage under the Commonwealth of Virginia's State Employee Health Insurance Plan or (2) is a patient in an institution for mental diseases or an inmate in a public correctional institution.
 - I will be responsible for paying a co-payment for some FAMIS services received by my child(ren).
 - I have the responsibility to report any changes in information provided on this form within 10 days of the change. I must report this information to the FAMIS office.
 - Medicaid, FAMIS, and DMAS contractors may verify any information that affects my child(ren)'s eligibility for insurance with other state and federal agencies.
- Medicaid, FAMIS, and DMAS contractors may exchange information on this application and medical, health or other information relating to my child(ren)'s coverage with other agencies and contractors, including companies offering health insurance to my child(ren), to assist with application, enrollment, administration, quality control and quality assurance. However, your information will not be shared with the Internal Revenue Service or Immigration and Naturalization Service.
 - The Commonwealth of Virginia or its designee has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by my child(ren).
 - Each provider of medical services to my child(ren) may release any medical or other information necessary for the provider to be paid.
 - All information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, my children's health insurance may be denied or ended and I could be prosecuted for perjury, larceny, and/or fraud.

SIGNATURE (REQUIRED) _____ DATE _____

RELATIONSHIP TO CHILD(REN) _____

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

CHILDREN'S HEALTH INSURANCE COMMUNICATION FORM

COUNTY/CITY:	MMIS ID NUMBER:
CASE NAME:	

Please cancel FAMIS coverage for the following child(ren) who has been found eligible for Medicaid. The FAMIS CPU must receive this form by the 10th of the month, for the FAMIS cancellation to be effective the last day of the current month. If the FAMIS CPU receives the form after the 10th of the month, FAMIS cancellation will be effective the last day of the following month.

NAME	SSN	DATE OF BIRTH	FAMIS RECIPIENT ID

The following change has been reported:

CHECK THE APPROPRIATE CHANGE	GIVE DATE CHANGE OCCURRED AND EXPLANATION
Moved or planning to move – give new address	
Change in income from a job	
Change in income other than from a job	
Change in the number of persons in the house	
Change in insurance status	
Other change	

(WORKER NAME/NUMBER)

(DATE)

(TELEPHONE NUMBER)

Please send completed form via the courier to the FAMIS Contract Monitor or fax to the FAMIS Contract Monitor 804-698-5654.

032-03-630 (9/02)

FAMIS ALIEN ELIGIBILITY CHART

QUALIFIED ALIEN GROUPS	ARRIVED BEFORE AUGUST 22, 1996	ARRIVED ON OR AFTER AUGUST 22, 1996	
		1 ST 5 YEARS	AFTER 5 YEARS
Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians Form DD 214-veteran	Eligible	Eligible	Eligible
Permanent Resident Aliens (Aliens lawfully admitted for permanent residence), except Amerasians I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)	Eligible	NOT Eligible	Eligible
Conditional entrants-aliens admitted Pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA I-94	Eligible	NOT Eligible	Eligible
Aliens, <i>other than Cuban or Haitian Entrants</i> , paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA I-94; I-688B – 274a(12)(c)(11)	Eligible	NOT Eligible	Eligible
Battered aliens, alien parents of battered children, alien children of battered parents U.S. Attorney General	Eligible	NOT Eligible	Eligible
	ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE		
Aliens granted asylum pursuant to section 208 of the INA I-94; I-688B – 274a.12(a)(5)	Eligible		
Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)} I-551; I-94; I-688B	Eligible		
Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA I-688-B – 274a.12(a)(10) Immigration Judge's Order	Eligible		
Victims of a severe form of trafficking pursuant to the Trafficking Victims Protection Act of 2000 (P.L. 106-386) [ORR certification/eligibility letter]	Eligible		

<p align="center">UNQUALIFIED ALIEN GROUPS</p> <p><u>NOT</u> ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE</p>	
Aliens residing in the US pursuant to an indefinite stay of deportation (I-94; Immigration Letter)	
Aliens residing in the US pursuant to an indefinite voluntary departure (I-94; Immigration Letter)	
Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure under 8 CFR 242.5(a)(2)(vi) and whose departure the INS does not contemplate enforcing (I-94; I-210)	
Aliens who have filed an application for adjustment of status pursuant to §245 INA that the INS has accepted as properly filed and whose departure the INS does not contemplate enforcing (I-181; Endorsed Passport)	
Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the INS whose departure the agency does not contemplate enforcing (I-94; Court Order; INS Letter)	
Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing (I-94; I-210; I-688B – 247a.12(a)(11) or (13))	
Aliens granted deferred action status pursuant to INS Operations Instruction 103.1(a)(ii) prior to 6/15/84 or 242.1a22 issued 6/15/84 and later (I-210; INS Letter)	
Aliens residing in the U.S. under orders of supervision (I-220B)	
Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 (Case Record)	
Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the INS does not contemplate enforcing (Immigration Judge Court Order)	
Any other aliens living in the US with the knowledge and permission of the INS whose departure the agency does not contemplate enforcing (INS Contact)	
Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired	
Visitors (non-immigrants): tourists, diplomats, foreign students, temporary workers, etc. (I-688B – 274a.12(b)(1)-(20); I-94; I-185; I-I186; SW-434; I-95A)	